MONTANA CHEMICAL DEPENDENCY CENTER POLICY AND PROCEDURE MANUAL

Policy Subject: Patient Consent for Treatment	
Policy Number: CTP 03	Standards/Statutes: ARM 37.27.130
Effective Date: 01/01/02	Page 1 of 3

PURPOSE: Provide patients with information necessary to make informed consent for participation in the treatment process.

POLICY: All patients will review and sign the consent foe treatment form and all appropriate release of information forms during the admission process.

PROCEDURE:

I. During the admission process, on the medical unit, the treatment specialist will meet with the patient and review the consent for treatment form.

II. The treatment specialist will clarify any questions the patient may have prior to obtaining a signature.

Revisions:_____

Prepared By: Stephen King Chemical Dependency Supervisor _____
Name Title Date

Approved By: _____
David J. Peshek, Administrator Date

MONTANA CHEMICAL DEPENDENCY CENTER

CONSENT FOR TREATMENT
&
GENERAL TREATMENT CONSIDERATIONS

I, the undersigned patient, voluntarily request admission, and treatment from, Montana Chemical Dependency Center (MCDC), an in-patient residential chemical dependency treatment facility. I give my consent to the provision of general health care services, which may include, but are not limited to: physical examination, laboratory tests and/or screenings, medications, and other medical procedures as may be deemed necessary and appropriate by the facilities attending physician to effectively treat my chemical dependency and any associated physical or psychological condition. I further understand, authorize and consent to be referred to specialized medical services, emergency services or acute hospital care, if my condition warrants such action be taken, and is being recommended by the attending physician of MCDC.

I understand that there is a charge for the services provided by MCDC and that I will be assessed these costs based upon my ability to pay, the determination of which shall be established at the time of admission from the Reimbursement Officer. I authorize MCDC to disclose to the Department of Public Health & Human Services, Reimbursement Bureau, and any pertinent medical or social information necessary to establish my ability to pay for treatment. Service providers outside MCDC, as may be necessary or required in the course of treatment, may provide other services. The bill for services provided outside MCDC may not be on an ability to pay basis, are the direct responsibility of the patient, and are separate from the MCDC patient account.

I have received, read, and understand my Patient Rights (ARM 20-33.2) as provided to me at the time of admission. I do, however, grant permission and authorize MCDC staff to inspect my personal belongings, at the time of admission and any time throughout my stay in the facility, for contraband items, which may include, but are not limited to: alcohol, drugs, weapons or other dangerous or unauthorized items.

During my course of stay at MCDC, I understand there is the possibility I may have a health emergency. In such an event, and given my inability to personally notify someone of the circumstance, I authorize and consent to allow MCDC staff to disclose the nature of the emergency to the following person(s):

Name (Please Print)	Relationship	Telephone #
Name (Please Print)	Relationship	Telephone #

Approved 11-26-02

The consent to authorize notification of emergency health care issues to the aforementioned individual (s) does not constitute an

authorization for release of any additional treatment information without a specific and separate release of information for these individuals.

Federal law and regulations protect the confidentiality of alcohol and drug abuse patient records maintained by this facility. Violation of the Federal law and regulations is a crime and suspected violations may be reported to appropriate authorities. Generally, MCDC staff may not disclose to a person outside this facility that a patient has been, or is currently, in treatment within this facility or disclose any information identifying a patient as an alcohol or drug abuser unless:

1. The patient consents to disclosure in writing,
2. The disclosure is allowed by a court order,
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or evaluation.

I understand that exceptions to my authorization for release of information exist under law. The professional staff of MCDC are obligated by law to report, without pre-authorization of consent, to the appropriate authorities, information pertaining to the following: suspicions of abuse or neglect to children, elderly, disabled or incompetent persons; capital crimes such as murder, rape, etc.; overt threats to harm another person; and communicable diseases.

All of the above consents shall automatically expire one year (12 months) after the date below, unless revoked by me in writing at an earlier date; with the exception that revocation does not apply to action that may have already been taken prior to a revocation either automatically or in writing.

I authorize Montana Chemical Dependency Center Staff to disclose to the DPHHS Reimbursement Bureau pertinent medical and social information for determining an equitable ability to pay the treatment coasts. This consent (unless expressly revoked earlier) expires upon the ending of the 12th month after my discharge.

PRINTED Patient Name:_____

_____

Patient Signature Date

_____

MCDC Staff Signature Date

NOTICE TO RECIPIENTS OF INFORMATION:
This information has been disclosed to you from records that are confidential and protected by federal law. Federal regulation (42CFR, Part 2) prohibits you from making any further disclosure of this information without the specific written consent from the person to whom it pertains or as otherwise may be permitted by the regulation. A general authorization for the release of medical or other information is not sufficient for this purpose.

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